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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/22/2011 | |
| NAME OF PROVIDER OR SUPPLIER WESLEY MANOR INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN46041 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| K0000 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/22/11</p> <p>Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wesley Manor Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility was surveyed under Chapter 18 due to the gutting and renovation of the health care wing located in the original building identified as F,</p> | | | K0000 | <p>Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor, Inc. provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the safety of long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents.</p> <p>As required, the facility submits the following plan of correction:</p> | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2011

FORM APPROVED

OMB NO. 0938-0391

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| | <p>and the addition of two new wings (G and H) in 2005.</p> <p>This facility was surveyed as two buildings due to different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement, was determined to be Type II (222). G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 96 and had a census of 85 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/29/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> | | | | | | |

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| K0021 SS=E | <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors to a hazardous area such as a kitchen was held open by a device which would allow the doors to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the activity room across the hall from the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the</p> | | | K0021 | <p>This tag was cited due to a dish cart holding open a door to the facility's service kitchen. Staff have been reminded of the life safety code requirement that any door that is held open, must be held open by a device which is mechanically supervised by the facility's fire alarm system so that it would automatically close in the event of a fire. Furthermore, staff were educated to place carts fully into the kitchen when emptying them, or to leave them in the access hallway until they are ready to be emptied. Compliance with this requirement will be monitored both formally and informally. Environmental rounds will be conducted on a formal basis at least monthly (See Attachment A) and will include monitoring for doors that are improperly held open in all parts of the facility. Additionally, the Health Facility Administrator, or his/her designee, will monitor</p> | | 07/22/2011 |

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| K0029 SS=E | maintenance director on 06/22/11 at 1:05 p.m. and later at 1:25 p.m., the corridor access door was held open by dish carts in the doorway. The maintenance director agreed at the time of the observations, the carts defeated the purpose for a self closing door. 3.1-19(b) | | | | compliance during daily rounds. Corrections for this tag will be completed by July 22, 2011. | | |
| | Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure hazardous areas such as soiled linen receptacle storage of more than 32 gallons within a 64 square foot area in 3 of 8 smoke compartments were located in a room equipped with self closing doors. This deficient practice a affects occupants of the G and H units with a census of 43 residents. | | | K0029 | This tag was cited due to 2 side-by-side linen/trash carts which have a 50 gallon capacity being kept in a corridor while not in use on 2 units. The facility has ordered new soiled linen and trash carts that are not side-by-side units with a capacity of only 32 gallons each. They will be used to replace the carts on Unit's G & H. Staff will be instructed to make certain that the 32-gallon carts are not stored within 64 square feet of each other when unsupervised unless they are stored in a utility room with a 1-hour fire rated barrier | | 07/22/2011 |

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| | <p>Findings include:</p> <p>Based on observations with the maintenance director on 06/22/11 between 10:15 a.m. and 3:30 p.m., resident rooms opened into a large open common area housing a dining area, activity space, nurses station and a TV lounge separated by a fixed partition which served to screen the lounge in the G and H resident sleeping room smoke compartments. The open area served as an exit corridor for emergency evacuation. One side of the partition was used as the collection point for soiled linens in two 50 gallon storage bins standing side by side against the partition. The bins were full. A sign posted above the receptacles on the partition between the nurses station and a lounge noted when the receptacles were to be emptied. The maintenance director said at the time of the observations, based on the signage the receptacles were "obviously stored there."</p> <p>3.1-19(b)</p> | | | | <p>with a 3/4 hour rated self-closing door. The facility will monitor compliance with this requirement both formally and informally. Environmental Rounds will be performed at least monthly (See Attachment A) and will include monitoring for this standard. Additionally, the Administrator or his/her designee will monitor this during daily rounds. Corrections for this tag will be completed by July 22, 2011.</p> | | |

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| K0044 SS=E | <p>Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 first floor fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects staff, visitors and 23 residents on F-1.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/22/11 at 1:45 p.m., the fire door set near room F112 was tested three times with the maintenance director. One door in the fire door set failed to latch each time the doors were released to close. The maintenance director commented at the time of observations, the door was dragging on the floor.</p> | | | K0044 | <p>This tag was cited due to one set of fire doors on the first floor of the facility's F-Wing failing to latch and/or fully close when the magnetic, alarm system-monitored, door hold was released. It is presumed, base on historical observation, that this door experienced some expansion associated with changes in temperature and humidity. Thus, the door's hardware was dragging along the carpeted floor preventing it from fully closing. The Maintenance Director immediately had the door serviced, which was successful in correcting the problem. The facility will educate all staff regarding the importance of monitoring the operation of all smoke and fire barrier doors. The facility will monitor compliance with this LSC requirement both formally and informally. Environmental rounds will be conducted at least monthly and will include monitoring the operation of fire and smoke barrier doors. Additionally, the Administrator or his/her designee will monitor for these types of problems during daily rounds. The corrections for this tag will be completed by July 22, 2011.</p> | | 07/22/2011 |

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| K0064 SS=D | <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the kitchen was installed at an approved height. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects 3 staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/22/11 at 1:50 p.m. , the top of the K class fire extinguisher was measured above the finished floor</p> | | | K0064 | <p>This tag was cited due to a K-class fire extinguisher, weighing 22 pounds, being installed so that the top of the extinguisher was greater than 60 inches above the floor. Additionally, this tag was cited due to a second extinguisher (ABC type) in the same kitchen being blocked by other kitchen equipment so that it could not be easily seen or accessed. The facility will move the K-Class extinguisher so that its top has a maximum height of 60 inches or less. The facility has moved a portable refrigeration unit so that the ABC type extinguisher can be easily seen and accessed by staff. Additionally, staff have been educated to refrain from placing carts or other equipment in front of this extinguisher. The facility will monitor compliance with the plan of correction both formally and informally. The Dietary Supervisor in charge of this service kitchen will conduct regular safety inspections in conjunction with regular sanitation audits to monitor these and any other potential safety hazards using the attached audit tool (See</p> | | 07/22/2011 |

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| | <p>in the kitchen at 70 inches. The maintenance director commented at the time of observation, "even I can't get that down."</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 kitchen portable fire extinguishers was located in an area where it was readily accessible to kitchen staff. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from an area. This deficient practice could affect 3 dietary staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/22/11 at 1:45 p.m.. one ABC fire extinguisher in the first floor kitchen was hung low on a wall, eight inches from a refrigeration</p> | | | | <p>Attachment B). The Administrator and/or his/her designee will monitor for this problem during environmental rounds (Attachment A) and during other informal rounds. Corrections for this tag will be completed by July 22, 2011.</p> | | |

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| K0075 SS=E | unit, and blocked with utility/dish carts. The maintenance director agreed at the time of observation, the fire extinguisher could not be readily seen and accessed. 3.1-19(b) | | | | | | |
| | Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 18.7.5.5 Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles with a total capacity exceeding 32 gallons capacity within any 64 square foot area were stored in a room protected as a hazardous area in 3 of 8 smoke compartments. This deficient practice affects occupants of the G and H units with a census of 43 residents. | | | K0075 | This tag was cited due to 2 side-by-side linen/trash carts which have a 50 gallon capacity being kept in a corridor while not in use on 2 units. The facility has ordered new soiled linen and trash carts that are not side-by-side units with a capacity of only 32 gallons each. They will be used to replace the carts on Unit's G & H. Staff will be instructed to make certain that the 32-gallon carts are not stored within 64 square feet of each other when unsupervised unless they are stored in a utility room | | 07/22/2011 |

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| | <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/22/11 between 10:15 a.m. and 3:30 p.m., resident rooms opened into a large open common area housing a dining area, activity space, nurses station and a TV lounge separated by a fixed partition which served to screen the lounge in the G and H resident sleeping room smoke compartments. One side of the partition was used as the collection point for soiled linens in two 50 gallon storage bins standing side by side against the partition. The bins were full. A sign posted above the receptacles on the partition between the nurses station and a lounge noted when the receptacles were to be emptied. The maintenance director said at the time of observations, based on the signage the receptacles were "obviously stored there."</p> <p>3.1-19(b)</p> | | | | <p>with a 1-hour fire rated barrier with a 3/4 hour rated self-closing door. The facility will monitor compliance with this requirement both formally and informally. Environmental Rounds will be performed at least monthly (See Attachment A) and will include monitoring for this standard. Additionally, the Administrator or his/her designee will monitor this during daily rounds. Corrections for this tag will be completed by July 22, 2011.</p> | | |

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| K0144 SS=F | <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 generators serving as the alternate source of power was maintained and capable of automatically connecting to the load within 10 seconds in the event of failure of normal power. NFPA 101, 4.6.12 requires equipment required for compliance with the provisions of the Code shall be continuously maintained. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load within 10 seconds. This deficient practice affects staff, visitors and 41 residents on the G and H units.</p> <p>Findings include:</p> | | | K0144 | <p>This tag was cited due to one of the facility's generators, located outside of the facility's G-Wing, failing to start due to warning lights which were signaling trouble. Additionally, the warning signals for both generators, need to be continually monitored via an annunciator panel in a regularly monitored area of the facility and the test logs for the generators must include the time for transfer of power from the main source to the generator. The facility has taken the following corrective actions: 1. A contractor has made the necessary repairs to correct the problems which activated the warning lights on the G-Wing generator. It has since been tested and operates without any difficulty. 2. The facility has ordered annunciator panels for both the F-Wing and G-Wing generators to be installed at a nursing station so that the potential for operational problems can be regularly monitored. 3. The facility has revised its generator testing logs to include the measurement of time required to transfer power from the main source of power to generator power. (See Attachment C) All Maintenance Department staff will be educated regarding proper response to the warning lights on generators and will be</p> | | 07/22/2011 |

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| | <p>Based on observation with the maintenance director and maintenance staff # 1 on 06/22/11 between 2:10 p.m. and 2:30 p.m., the GG generator failed to start when maintenance man # 1 tried to demonstrate it's operation. Trouble lights were flashing on the generator panel on the generator. A check of the annunciator panel in the electrical room revealed trouble lights were flashing there too. The maintenance director immediately called maintenance staff # 3 who is charged with the operation and maintenance of the generator. He suggested a means of starting the generator from the transfer switch room. It did not start.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview; the facility failed to ensure 2 of 2 emergency generators were provided with alarm annunciators in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities,</p> | | | | <p>cross-trained regarding basic trouble-shooting for the generators. Nursing staff working where the annunciator panels are located will be educated to respond appropriately to any warning signals r/t the the generators. Compliance with these corrections will be monitored during the facility's environmental rounds (See Attachment A) where generator testing logs will be observed in order to make certain that annunciator panel operation and transfer time are being monitored adequately. Corrections for this tag will be completed by July 22, 2011.</p> | | |

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| | 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall | | | | | | |

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| | <p>be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all patients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/22/11 between at 2:35 p.m. and 3:15 p.m., the facility's two emergency generator remote alarm annunciators were not located in continuously monitored areas. The annunciator for the GG generator was located on a panel in the basement generator room. Two annunciators were available for the FB emergency generator, one on the generator itself located outside the building and another on the wall of a basement electrical room. None of the annunciators were in areas monitored continuously. In addition, the FB trouble lights were flashing on both panels. No alarm was annunciated and the</p> | | | | | | |

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| | <p>maintenance director and maintenance staff # 1 and # 2 were unaware of the trouble condition, and could not say what the trouble was based on the panel. The maintenance director said, at the time of observations, the maintenance man responsible for handling the emergency generators was away on vacation.</p> <p>3.1-(19) b</p> <p>3. Based on interview and record review, the facility failed to provide the complete documentation for testing 2 of 2 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of</p> | | | | | | |

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| | <p>30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator Weekly Test Logs and Emergency Generator Monthly test logs with the maintenance director on 06/22/11 at 3:15 p.m., the emergency generators were tested monthly under load for 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator for either the FB3 generator or the GH generator for since May 2011. The maintenance director said, it appeared a new log for documenting all information had not been used resulting in the omissions.</p> <p>3.1-19(b)</p> | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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